



## New Patient Intake

### Patient Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Marital Status: S M W D

Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Is it okay if we communicate via phone, text, and email messaging concerning your care and appointments?  Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How were you referred to this office?: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for visit: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your PCP regarding your care at this office?  Yes  No

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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### Purpose for this Visit

Reason for this visit: \_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work-related)?  Yes  No

Describe incident or reason for onset of symptoms: \_\_\_\_\_

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Have you been treated for this previously?  Yes  No When was the last treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of treating practitioner/facility: \_\_\_\_\_

What treatment(s) was performed?: \_\_\_\_\_

How did you respond to this treatment?: \_\_\_\_\_

Medications prescribed/taking for this condition: \_\_\_\_\_

# Current Health Information

Please list all symptoms that you are experiencing today.

1) Symptom: \_\_\_\_\_ Onset Date: \_\_\_\_\_

Is it getting progressively worse:  Yes  No  Constant  Comes and Goes

Is this condition interfering with your:  Work  Sleep  Daily Routine  School

Explain: \_\_\_\_\_  
\_\_\_\_\_

Rate your level of pain: No pain = 0 1 2 3 4 5 6 7 8 9 10 = Extreme Pain

Frequency of pain:  Daily  Weekly /  Occasional  Intermittent  Frequent  Constant

What makes it feel better? \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

2) Symptom: \_\_\_\_\_ Onset Date: \_\_\_\_\_

Is it getting progressively worse:  Yes  No  Constant  Comes and Goes

Is this condition interfering with your:  Work  Sleep  Daily Routine  School

Explain: \_\_\_\_\_  
\_\_\_\_\_

Rate your level of pain: No pain = 0 1 2 3 4 5 6 7 8 9 10 = Extreme Pain

Frequency of pain:  Daily  Weekly /  Occasional  Intermittent  Frequent  Constant

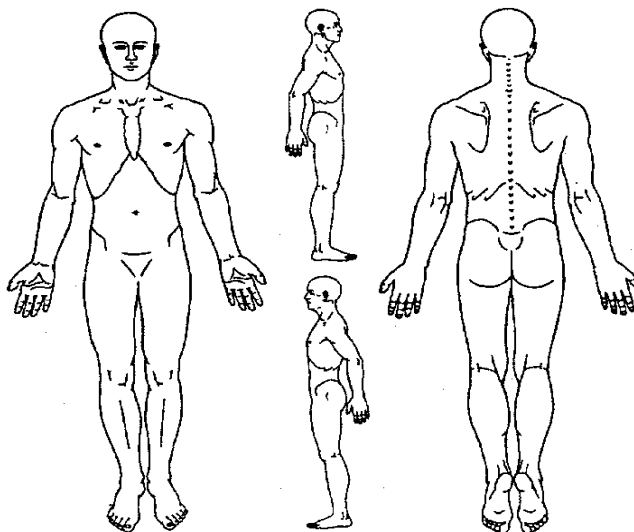
What makes it feel better? \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

## Pain Diagram

On the following diagram, please indicate all areas of

Pain – XXX      Stiffness - ///      Numbness – OOO      Other - \_\_\_\_\_



## Current Health Information

Please list any additional symptoms you are currently experiencing, even if you feel they do not relate to your spine or chief complaint:

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Health conditions you are currently being managed/treated for:

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Current medications and Supplements (include name and for what condition):

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## Previous Health History

List any surgeries and date: \_\_\_\_\_

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List any major trauma / accidents / injuries and date: \_\_\_\_\_

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List any major illness or health condition and date: \_\_\_\_\_

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Have you seen a Chiropractor before:  Yes  No Who? \_\_\_\_\_

Reason for visit(s): \_\_\_\_\_

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## Family Healthy History

Do you have a family history of Cancer, Heart disease, Diabetes, Auto-immune Conditions or Arthritis?  
(If yes, please list family member, age, and condition of disease.)

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## Insurance

Barnes Chiropractic is a participating network member for Excellus Blue Cross Blue Shield, Blue Cross Blue Shield Blue Card Program, Aetna, Landmark, and Medicare. Each individual plan for these companies is different and may or may not include Chiropractic coverage; your insurance policy may have limitations, deductibles, co-payments or may not cover certain services. Every effort will be made by our office to verify your insurance benefits and confirm the details of coverage; however, as stated by the insurance companies, verification is never a guarantee of coverage and this may change at any time without the insurance company notifying our office or you of this change at the time it occurs. Your insurance plan is a contract between you and your insurance company. This clinic is not party to that contract and therefore cannot modify the terms of that contract.

Insurance Carrier: \_\_\_\_\_ Member ID: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Payment Policy

Payment for treatment you receive at Barnes Chiropractic is your responsibility whether your insurance company pays or not. Payment is expected at the time services are rendered; detailed receipts are available upon request. If your insurance company denies your claim, you will be responsible for the balance. This office accepts all major credit cards, debit cards for health savings and flex spending accounts, personal checks, and cash. Any checks returned for insufficient funds will be charged a \$37.00 fee. Any unpaid, unresolved balances will be forwarded to our collection agency after 60 days.

## Assignment of Benefits

I authorize payment of insurance benefits directly to Alicia L Barnes, DC, CCSP or Barnes Chiropractic. I authorize the release of any information pertinent to my case to any insurance company, adjustor, or healthcare providers to secure payment of benefits. My signature below is a direct assignment of my rights and benefits under this policy.

## HIPAA / Notice of Privacy Practices Acknowledgement

I understand that I have certain right or privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like a more detailed account of your privacy rights as a patient, a HIPAA notice is available to you at the front desk. If there is anyone you do not want to receive your medical records, please inform our office.

## Appointments, Scheduling, and Cancellation Policy

As a courtesy to all our patients, we strive to maintain a smooth and time efficient practice while addressing our patient's individual healthcare needs. As a patient of this practice you agree to keep all your scheduled appointments. If for some reason you need to cancel or reschedule your appointment, 24-hour notice is required (email and voicemail messages are acceptable forms of cancellation). **Missed appointments or cancelling outside the 24-hour period will result in a \$50.00 fee not coverable by insurance.** Missed appointment fee will be charged day of cancellation.

Please sign your name and date below to acknowledge that you have read, understand, and agree to Barnes Chiropractic's Insurance and Payment Information, Assignment of Benefits, Notice of Privacy Practices, and Appointments and Cancellation Policies.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_